

**Special Needs Project
Screening Report Form
Demonstration Site, County Commission**

Child's name _____	Date of screening completion: _____
Name of person who completed this form: _____	Phone number: _____
<i>The following documents are attached:</i>	
<input type="checkbox"/> INC/Core participant client profile (AB 99 identifying information) <input type="checkbox"/> Parental consent for participation in the School Readiness Initiative program/screening process <input type="checkbox"/> Parental consent for participation in the statewide evaluation of First 5 California for the Special Needs Project <input type="checkbox"/> ASQ Information Summary sheet <div style="margin-left: 40px;">Was child born more than 3 weeks early? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div style="margin-left: 40px;">If Yes, how many weeks early? <input style="width: 50px; border: 1px solid black;" type="text"/></div> <div style="margin-left: 40px;">Parental concerns needing follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Declined</div> <input type="checkbox"/> ASQ: SE Information Summary sheet <div style="margin-left: 40px;">Parental concerns needing follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Declined</div> <input type="checkbox"/> PSI/SF test sheet <input type="checkbox"/> Health screening form <input type="checkbox"/> Addition of a guardian to a core participant/prenatal parent <input type="checkbox"/> Intake form	
<i>Comments on screening process/tools:</i>	
<i>Reason for missing forms (if any):</i>	
<i>To be completed by the child study team: What was the outcome or recommendation of the screening?(Select only one)</i>	
<input type="checkbox"/> No concerns. No risk factors. <input type="checkbox"/> No concerns. Risk factors present. <input type="checkbox"/> Recommend for assessment. <input type="checkbox"/> Don't know/Declined.	
<i>To be completed by the child study team: If the child and/or family received one or more referrals please name the agency or agencies.</i>	
Referral agency 1: _____ Date of referral 1: (mm/dd/yyyy) _____ Referral type: <input type="checkbox"/> Assessment <input type="checkbox"/> Service Referral agency 2: _____ Date of referral 2: (mm/dd/yyyy) _____ Referral type: <input type="checkbox"/> Assessment <input type="checkbox"/> Service	Referral agency 3: _____ Date of referral 3: (mm/dd/yyyy) _____ Referral type: <input type="checkbox"/> Assessment <input type="checkbox"/> Service